

Virginia Department of Health
Outbreak Reporting Form for Suspected or Confirmed Influenza in Facilities*

General Information

Today's Date: ____/____/____

Epidemiology Outbreak ID Number: _____ District: _____

Health department contact person: _____ Telephone: _____

Outbreak Information

Facility Name: _____ Facility City or County: _____

Facility Type: ☐ Nursing home ☐ Assisted living ☐ Other, specify: _____

Date health department notified: ____/____/____

Date of first case: ____/____/____ Date of last case: ____/____/____

Does the facility have a standing orders program for vaccination of residents? ____ For antiviral use? ____

Residents	
Number of residents ill:	
Number of residents vaccinated before outbreak:	
Total number of residents of the facility:	

Staff	
Number of staff ill:	
Number of staff vaccinated before outbreak:	
Total number of staff employed by the facility:	

Illness Characteristics

Predominant symptoms (check all that apply): ☐ Fever ☐ Cough ☐ Sore throat
☐ Myalgia ☐ Other, specify: _____

Average duration of illness (specify hours or days): _____

Number of residents admitted to a hospital: _____ Number of residents who died: _____

Laboratory Information

Number of rapid tests administered _____ Number positive (specify type, if known) _____

Name of rapid test (e.g., Quickview) _____

Number of persons for whom specimens were collected and sent to DCLS _____

Specify: Number of DFA positive results _____ Type of influenza indicated _____
Number of culture positive results _____ Type/strain of influenza indicated _____

Public Health Interventions (check all that apply):

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> Antivirals administered, specify: | # Receiving for prophylaxis _____ | # Receiving for treatment _____ |
| <input type="checkbox"/> Vaccination: | # Receiving _____ | |
| <input type="checkbox"/> Closed to new admissions | | |
| <input type="checkbox"/> Increased surveillance for respiratory illness | | |
| <input type="checkbox"/> Conducted in-service/education on handwashing | <input type="checkbox"/> Other, specify: _____ | |
| <input type="checkbox"/> Instituted droplet precautions | | |
| <input type="checkbox"/> Restricted visitation | | |
| <input type="checkbox"/> Cohorted ill residents | | |
| <input type="checkbox"/> Cohorted staff to work with ill or well | | |
- Date facility first started implementing control recommendations: ____/____/____

When you first suspect an outbreak, please notify DSI immediately through your regional epidemiologist or the central office (if regional epidemiologist is not available). After the investigation is closed, submit this form to DSI through your regional epidemiologist or by fax to 804-864-8139.

*Facilities may be nursing homes, schools/daycares, correctional facilities, or other similar types of facilities.